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ABSTRACT

Therapeutic communication, or interaction which provokes personal insight or reorientation, can be best understood as a transactive, rather than linear, interrelationship between people or groups. Two practical responses to "pathological" communication patterns illustrate the validity of the transactional communication theory: the psychiatric response, in which the patient manipulates the therapist through the strategic use of transactional processes, and the transactional-analysis response, in which interpersonal games are interrupted by the therapist's avoidance of complementary transactions. (KS)

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THE TRANSACTIVE NATURE

OF

THERAPEUTIC COMMUNICATION

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Rossiter (1975) argues that any contemporary view of therapeutic communication should adopt a "transactive view" as opposed to a linear or interactive view. This paper represents an attempt to provide such a viewpoint.

Therapeutic Communication

First of all, what is meant by the term therapeutic communication? Barnlund (1968) writes that,

> . . .Interpersonal communications are destructive when they leave participants more vulnerable than before to the strains of future interactions; they are neutral when they add information but do not affect underlying values or attitudes; they are regarded as therapeutic when they provoke personal insight or reorientation, and when they enable persons to participate in more satisfying ways in future social encounters. (p. 614)

Reusch (1961) describes the holistic nature of therapeutic communication when he writes,

> . . .a child can be therapeutic for the mother and a boss can be therapeutic for his employee; therapy is done all day long by many people who do not know that they act as therapists, and many people benefit from such experiences without knowing it. Therapeutic communication is not a method invented by physicians to combat illness; it is simply something that occurs spontaneously everywhere in daily life, and the physician is challenged to make these naturally occurring events happen more frequently. (p. 31)

Although therapeutic communication can apply to these various situations as described above, the most intense need is for the individual suffering from and manifesting pathological communication. Pathological communication is described by Reusch (1957) as <u>inappropriate</u>. He writes,

> . . .Either it does not fit the circumstance ot is is irrelevant and is not matched to the initial statement. The reply may be exaggerated, as in the case of the person who explodes or is

> visibly upset when asked a polite question; or it may be overwhelming, as it is to a child who asks for a utensil and is immediately given a whole battery of implements. (p. 43)

A more severe form of inappropriateness occurs with the person suffering from a form of neurosis called hysteria. A person may develop hysterical blindness or paralysis for which there is no physical cause. In other words, the malady is psychologically induced. The person is trying to communicate in a very crude nonverbal way that he wants attention and needs help. The same is often true of the person who repeatedly attempts suicide. Sexual secondary impotence and frigidity are other types of nonverbal messages indicating psychological disturbances. For lack of a better term, these communication attempts may be called protocommunication (prototypes of communication). They are crude substitutes for the real thing just as a prototype is a relatively simplified version of a real machine.

Undoubtedly the most severe forms of pathological communication occur among psychotics. Catatonics sit or stand in statue-like poses in a perpetual state of withdrawal. Hebephrenic schizophrenics make up their own language so that no one else can understand their "word salad" form of speech. Manic-depressives rant and rave and bang their heads against the walls only to change into periods of deep depression and melancholea. The paranoid will suffer from delusions of grandeur and imagine that he is Christ or Napolean and that everyone is plotting to kill him because of their jealousy. Finally, the schizophrenics who imagine they hear voices and who may also have visual hallucinations, use these methods to withdraw from normal contact with other human beings since previous contacts have been too painful to continue. These severe pathologies require a highly trained expert with a great deal of experience in therapeutic communication.

The Transactive Viewpoint

The transactive viewpoint toward therapeutic communication first of

all assumes that all behaviors are potentially communicative. A study by Minter (1968) revealed that the most preferred definition of a sample of sixty-two communication scholars was that of Reusch and Bateson (1951) which states that,

> Communication does not refer to verbal, explicit, and intentional transmission of messages alone. . . . The concept of communication would include all those processes by which people influence one another. . . . This definition is based upon the premise that all actions and events have communicative aspects, as soon as they are perceived by a human being; it implies, furthermore, that such perception changes the information which an individual possesses and therefore influences him. (p. 5 and 6)

More recent writings of Sereno and Bodaken (1975) and Wilmot (1975) stress that the participants in any communication event are highly interdependent upon one another. They are simultaneously influencing one another and are both senders and receivers at all times. Wilmot (1975) goes so far as to state that, ". . .The process of your creating a message may affect you more than it does the person receiving it." Your participation in an encounter means it will affect you, whether you are primarily creating or primarily deciphering the verbal message. Research on cognitive balance theory by Berscheid and Walster (1969) and the research in counter-attitudinal advocacy certainly support this assertion (c.f., Burgoon, Miller and Tubbs, 1972).

The transactive viewpoint can be summarized by stating that a person's communication can only be defined in relation to some other or others. Probably one of the most extreme examples of this with respect to therapeutic communication is the pathology referred to as folie a deux. Pronko (1963) describes it in this passage, ". . .No matter how soon after the first person develops delusions, the second one shows them also; it appears certain that one developed them first and transferred them to the partner. . ." (p. 275) Pronko goes on to state that foliex a trois and a Quatre have been documented as well as shared delusions among groups as large as eighteen. (p. 276) The point is

that the pathology is shared and is a relevant part of the way in which the participants have formulated their relationship.

Watzlawick, et.al. (1974) cite another interesting example of the transactive nature of pathological and therapeutic communication. Patients in mental institutions figure out the best way to get cured and released from the hospital. The procedure goes like this:

A. Develop a flamboyant symptom that has considerable nuisance value for the whole ward;

B. Attach yourself to a younger doctor in need of his first success;

C. Let him cure you rapidly of your "symptom"; and

D. Make him thus into the most fervent advocate of your regained sanity. (p. 70).

It is obvious from this example that the behaviors of the doctor are very much a part of the plan of the patient to be released. This beautifully illustrates the transactive nature of therapeutic communication.

The transactive viewpoint is very much related to what is usually referred to as the systems theory approach. Although it is beyond the scope of this paper to go into systems theory principles here, the interested reader may want to see Ruben (1972), Ruben and Kim (1975), and Tubbs (1978 in press).

A Psychiatric Response

In response to the tendency of patients to take advantage of the transactive nature of attempts at therapeutic communication, Watzlawick, et.al. (1974) have conceptualized an intervention model which is relevant to this discussion. They describe first-order

change as the therapist's reaction to the client. If the client complains of problems, the therapist tries harder to help solve them. More problems arise, and the therapist tries still harder. The net effect of attempts at first-order change, is the French proverb "Plus ca change, plus c' est la meme chose." In English, the more things change, the more they stay the same.

In contrast, second-order change includes attempts to change the method of change. It involves in most cases, a counterintuitive approach. For example, in one case, a thirty year old schizophrenic male had spent ten years in mental hospitals. He had repeatedly been told he should become competent, get a job, start a new life, etc. In every case the attempts at therapeutic communication failed. Watzlawick, et.al. (1974) describes the second order change technique.

> . . .A very different situation arises if one takes the why-should-you change? approach. Instead of countering nonsense with common sense (a pair of opposites which together establish persistence rather than change), the Judo technique of utilizing the other's resistance is the method of choice: "I know I should not tell you this, because what are you going to think of a doctor who says such things; but strictly between you and me I must tell you what I really think of your situation. As far as I am concerned, it is I who should have his head examined, not you. Because you have made it, you have found a way of life which most of us would dearly love to live. When I wake up in the morning, I face a day in which ninety-nine things are likely to go wrong, I face ten miserable hours of all kinds of responsibilities and problems. And you don't even have to get up if you don't want to, your day is safe and predictable, you will have three meals served to you, you will probably play golf in the afternoon and watch a movie in the evening. You know that your parents will continue to pay for your stay in the hospital, and when they eventually die you can be certain that the State will look after you. Why on earth should you exchange your style of life for some stupid rat race like mine?" If this theme is sufficiently developed and consistently maintained, the patient will soon respond to it with something like, "What are you--some kind of a nut, doctor? I should be out of his place, have a job, and lead my own life--I am fed up with being a patient." (Again, the reader should bear in mind that the foregoing is presented not as a "cure" for "mental illness," but as an illustration of a second-order change technique.) A variant of this intervention is the question: "How could you possibly change?" (p. 134-5)

Perhaps a second example will add even more clarity to this method of therapeutic communication. Watzlawick, et.al. (1974) writes:

> A teenage boy had been suspended from school after he was caught selling barbiturates on the school grounds. He was annoyed, not so much because he would be missing school, but because his "business" would be interfered with. His annoyance became intense anger when the principal told him that the suspension was "for his own good and to help him." While he was to be suspended, the principal informed him, he would be given credit for any work he did on his own at home--homework assignments, preparing for examinations, etc.--and his mother would be allowed to pick up these assignments at school and bring them home to him. Since the boy had not been much of a student to begin with, but now was furious with the principal over the suspension, he announced to his mother that he would be damned if he would do any schoolwork. It was at this point that the mother sought help.
>
> Her hope was that the therapist could get the boy into his office and somehow make him accept the principal's ruling so that he would not remain so angry and therefore intransigent about schoolwork. Instead, the therapist, realizing that the boy's anger with the principal afforded a lever for change, instructed the mother as follows: She was to go home and simply tell the boy that she had talked over his situation with some other mothers and had come to realize something, but that she was not sure whether she should tell him what it was. After some brief hesitation she was to go ahead and come out with this troublesome "realization": that his principal was noted for stressing the importance of students attending classes, that he believed quite firmly that a student just could not keep up with his studies without faithful attendance, and that he had probably suspended him to make him fail the entire school year. She was then to point out to the boy that if during his suspension from school he should do as well or even better on his own than when he attended class, the principal would be very red-faced and embarrassed. She was to finish this narrative by suggesting that it might be for the best if he did not "do too well," and thereby save the principal's face. The mother subsequently reported to the therapist that when he heard this, her son's face lit up with a diabolical grin and revenge shone in his eyes. He had found a way to gain retribution, and it mattered little that it would require his buckling down to work. In a follow-up session the mother reported that her son had thrown himself into the schoolwork "with a vengeance" and was beginning to get better grades than ever before. (p. 137-8)

These examples of <u>second-order change</u> techniques are similar to those introduced by Frankl (1972) with his Logotherapy. He had a

patient who complained of insomnia. Frankl advised him to stay awake as much as possible night and day and to keep it up as long as he could. It wasn't long before the man became so tired that his body forced him to sleep. Another patient worried about perspiring in public; Frankl instructed him to sweat as much as he could. The problem was cured shortly. It is clear that second-order change requires the therapist to become part of the craziness of the patients' world in order to play an effective role.

A Transactional Analysis Response

In Eric Berne's writings the idea of the "game" aspects of therapy is dealt with at some length. A game is an ulterior transaction which leads to a payoff (Berne, 1964, p. 48). According to Woollams, et.al. (1974) a game can be diagrammed as follows:

$$C + G = R \rightarrow S \rightarrow X \rightarrow P$$

Con + Gimmick = Response → Switch → Crossup → Payoff

(The underlining was added by the authors to illustrate that the three last events often occur simultaneously.)

CON: A's desire to play a game is initiated by a discount (his con). "Let me help you," is given verbally while the nonverbal message is "You're inferior to me."

GIMMICK: B also discounts (and reveals the part of him that is interested or hooked by the con, which is his gimmick) and responds to the secret message. His verbal response is "Help me." The nonverbal message is "You're right, I am inferior."

RESPONSE: A series of social messages follows, usually Adult to Adult (A "helps" B by telling him what to do).

SWITCH: Each player switches ego states and the secret messages become apparent. A says "You can't be helped. You really are inferior." He now shows that he is a Presecutor and not a helper. B says "This proves it. I really am no good."

CROSSUP: A moment of confusion is experienced by each player. B may momentarily wonder, "What happened? I thought he was trying to help me."

PAYOFF: Bad feelings are experienced by each player. A feels superior after

having played "NIGYSOB" and B feels depressed after having played "Kick Me."

The following is a list of common games divided into groups determined by the three Game Triangle positions. The first game in each column is the basic one for that position.

PERSECUTOR	RESCUER	VICTIM
NIGYSOB	I'm Only Trying To Help You	Kick Me
Blemish	What Would You Do Without Me	Why Does This Always Happen To Me?
Courtroom	Happy To Help	Stupid
If It Weren't For You	They'll Be Glad They Knew Me	Wooden Leg
Rapo		Harried
See What You Made Me Do		Poor Me
Corner		Cops & Robbers
Schlemiel		Alcoholic, Addict

The recommended approach for breaking up the game is to avoid complementary transactions but go to a crossed transaction which interrupts the course of the game and fails to provide the payoff. The examples of second-order change fit this approach perfectly. Interested readers may want to consult Goldhaber and Goldhaber (1976) for an excellent treatment of the transactional analysis approach.

This paper has attempted to (1) define therapeutic communication, and (2) provide a transactive viewpoint of therapeutic communication. In addition, two practical responses which can be used to implement this approach have been discussed: (1) a psychiatric response, and (2) a transactional analysis response. Note also that these methods apply to daily attempts at therapeutic communication as the Barnlund quote mentioned earlier in this paper. Thereapeutic communication need not be limited to the psychiatrist's office.

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